FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042671

Facility Name: PRAIRIE VILLAGE HEALTHCARE CENTER

Address: 1024 W. WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4149930

Date of Initial License for Current Owners: 05/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/01/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	46,116	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,429	497	1,401	5,327	8
9	SNF/PED					9
10	ICF	25,146	2,612		27,758	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,575	3,109	1,401	33,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 71.74%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1401

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE C # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,752	9,981	5,998	127,731		127,731	0	127,731			1
2	Food Purchase		119,210		119,210	(11,968)	107,242	(936)	106,306			2
3	Housekeeping	94,634	9,763	0	104,397		104,397	0	104,397			3
4	Laundry	46,860	11,185	0	58,045		58,045	0	58,045			4
5	Heat and Other Utilities			75,689	75,689		75,689	273	75,962			5
6	Maintenance	22,014	35,165	19,266	76,445		76,445	9,189	85,634			6
7	Other (specify):*			7,070	7,070		7,070	0	7,070			7
8	TOTAL General Services	275,260	185,304	108,023	568,587	(11,968)	556,619	8,526	565,145			8
	B. Health Care and Programs											
9	Medical Director			4,090	4,090		4,090	0	4,090			9
10	Nursing and Medical Records	688,716	38,562	2,916	730,194		730,194	15,782	745,976			10
10a	Therapy	65,037	3,782	21,671	90,490		90,490	(2,115)	88,375			10a
11	Activities	32,883	1,845	0	34,728		34,728	0	34,728			11
12	Social Services	1,573		2,310	3,883		3,883	0	3,883			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	788,209	44,189	30,987	863,385		863,385	13,667	877,052			16
	C. General Administration											
17	Administrative	74,360		113,000	187,360		187,360	(44,008)	143,352			17
18	Directors Fees			0				0				18
19	Professional Services			190,720	190,720		190,720	(116,708)	74,012			19
20	Dues, Fees, Subscriptions & Promotions			26,091	26,091		26,091	(11,831)	14,260			20
21	Clerical & General Office Expense	85,235	7,388	77,820	170,443		170,443	(26,454)	143,989			21
22	Employee Benefits & Payroll Taxes			162,327	162,327	11,968	174,295	0	174,295			22
23	Inservice Training & Education			2,810	2,810		2,810	640	3,450			23
24	Travel and Seminar			2,592	2,592		2,592	71	2,663			24
25	Other Admin. Staff Transportation			2,215	2,215		2,215	808	3,023			25
26	Insurance-Prop.Liab.Malpractice			52,602	52,602		52,602	2,404	55,006			26
27	Other (specify):*			0				16,733	16,733			27
28	TOTAL General Administration	159,595	7,388	630,177	797,160	11,968	809,128	(178,345)	630,783			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,223,064	236,881	769,187	2,229,132		2,229,132	(156,152)	2,072,980			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE C # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,270	44,270		44,270	28,351	72,621			30
31	Amortization of Pre-Op. & Org.			1,597	1,597		1,597	0	1,597			31
32	Interest			74,628	74,628		74,628	166,064	240,692			32
33	Real Estate Taxes			22,289	22,289		22,289	0	22,289			33
34	Rent-Facility & Grounds			208,800	208,800		208,800	(205,165)	3,635			34
35	Rent-Equipment & Vehicles			39,380	39,380		39,380	(7,480)	31,900			35
36	Other (specify):*							0				36
37	TOTAL Ownership			390,964	390,964		390,964	(18,230)	372,734			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		24,667	57,723	82,390		82,390	(16,958)	65,432			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			69,174	69,174		69,174	0	69,174			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		24,667	126,897	151,564		151,564	(16,958)	134,606			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,223,064	261,548	1,287,048	2,771,660	0	2,771,660	(191,340)	2,580,320			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,080)	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(936)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,796)	21		18
19	Entertainment				19
20	Contributions	(101)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(88)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,506)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule DEFERRED MAINTENANCE XIX-H	1,347	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,189)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(162,151)		34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (162,151)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (191,340)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name PRAIRIE VILLAGE HEALTHCARE CENTER

ID# 0002671

Report Period Beginning: 01/01/2008

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(956)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	1,347
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	411
9	**Non-Straightline Depreciation**	(11,080)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(29)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(956)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	0
18	**Fines and Penalties**	(3,796)	21	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	(101)	20	**Line 19**	100
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(12,447)
22	**Special Legal Fees & Legal Retainers**	(88)	19	**Line 21**	15,792
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(12,506)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(16,497)
30	**Donated Goods**	0	0	**Line 29**	(16,500)
31	**Amortization Expense**	0	0	**Line 30**	(13,080)
32	PG 5 LINE 29 - DEFERRED MAINTENANCE X	1,347	6	**Line 31**	0
33				**Line 32**	(29)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(13,189)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(29,189)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(936)	0	0	0	0	0	0	0	0	0	0	(936)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	273	0	0	0	0	0	0	0	0	0	273	5
6	Maintenance	1,347	7,842	0	0	0	0	0	0	0	0	0	9,189	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	411	8,115	0	0	0	0	0	0	0	0	0	8,526	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,782	0	0	0	0	0	0	0	0	0	15,782	10
10a	Therapy	0	4,220	(6,335)	0	0	0	0	0	0	0	0	(2,115)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	20,002	(6,335)	0	0	0	0	0	0	0	0	13,667	16
	C. General Administration													
17	Administrative	0	(44,008)	0	0	0	0	0	0	0	0	0	(44,008)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(88)	(116,620)	0	0	0	0	0	0	0	0	0	(116,708)	19
20	Fees, Subscriptions & Promotions	(12,607)	0	776	0	0	0	0	0	0	0	0	(11,831)	20
21	Clerical & General Office Expenses	(3,796)	(60,720)	38,062	0	0	0	0	0	0	0	0	(26,454)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	640	0	0	0	0	0	0	0	0	640	23
24	Travel and Seminar	0	0	71	0	0	0	0	0	0	0	0	71	24
25	Other Admin. Staff Transportation	0	0	808	0	0	0	0	0	0	0	0	808	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,404	0	0	0	0	0	0	0	0	2,404	26
27	Other (specify):*	0	0	16,733	0	0	0	0	0	0	0	0	16,733	27
28	**TOTAL General Administration**	(16,491)	(221,348)	59,494	0	0	0	0	0	0	0	0	(178,345)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,080)	(193,231)	53,159	0	0	0	0	0	0	0	0	(156,152)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

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	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,080)	0	41,431	0	0	0	0	0	0	0	0	28,351	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29)	0	166,093	0	0	0	0	0	0	0	0	166,064	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(205,165)	0	0	0	0	0	0	0	0	(205,165)	34
35	Rent-Equipment & Vehicles	0	0	(7,480)	0	0	0	0	0	0	0	0	(7,480)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,109)	0	(5,121)	0	0	0	0	0	0	0	0	(18,230)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(16,958)	0	0	0	0	0	0	0	0	(16,958)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	(16,958)	0	0	0	0	0	0	0	0	(16,958)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,189)	(193,231)	31,080	0	0	0	0	0	0	0	0	(191,340)	45

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTEI # 0042671 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1 V	17	MANAGEMENT FEES	77,000	CAREPLUS MGMT INC	0	0	(77,000)	1	-77000
2 V	19	ADMIN. CONSULTANT FEES	110,000	" "			(110,000)	2	-110000
3 V	19	DATA PROCESSING FEES	8,800	" "			(8,800)	3	-8800
4 V	21	CLERICAL FEES	60,720	" "			(60,720)	4	-60720
5 V				" "				5	
6 V				" "				6	
7 V	5	ELECTRICITY		" "		273	273	7	273
8 V	6	REPAIRS		" "		482	482	8	482
9 V	6	MAINTENANCE SALARIES		" "		7,360	7,360	9	7360
10 V	11	NURSING		" "		15,782	15,782	10	15782
11 V	10a	THERAPY SALARIES		" "		4,220	4,220	11	4220
12 V	17	ADMIN SALARIES		" "		32,992	32,992	12	32992
13 V	19	PROFESSIONAL FEES		" "		2,180	2,180	13	2180
14 Total			$ 256,520		$ 0	63,289	$ * (193,231)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 776	$ 776	15	776
16	V	21	OFFICE SALARIES/EXPENSES		" "		38,062	38,062	16	38062
17	V	23	SEMINARS		" "		640	640	17	640
18	V	24	TRAVEL		" "		71	71	18	71
19	V	25	TRANSPORTATION		" "		808	808	19	808
20	V	26	INSURANCE		" "		2,404	2,404	20	2404
21	V	27	EMPLOYEE BENEFITS		" "		16,733	16,733	21	16733
22	V	30	SL DEPRECIATION		" "		5,954	5,954	22	5954
23	V	32	INTEREST		" "		597	597	23	597
24	V	34	OFFICE RENT		" "		3,635	3,635	24	3635
25	V	35	EQUIP RENT/AUTO LEASE	12,018	" "		4,538	(7,480)	25	-7480
26	V								26	
27	V								27	
28	V								28	
29	V	10a	THERAPY SERVICES	21,563	CAREPLUS REHABILITATIVE SERVICES		15,228	(6,335)	29	-6335
30	V	39	ANCILLARY THERAPY	57,722	" "		40,764	(16,958)	30	-16958
31	V								31	
32	V								32	
33	V	34	RENT	208,800	PRAIRIE VILLAGE HEALTHCARE CENTER LLC			(208,800)	33	-208800
34	V	30	SL DEPRECIATION		" "		35,477	35,477	34	35477
35	V	32	INTEREST		" "		165,496	165,496	35	165496
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 300,103			$ 331,183	$ * 31,080	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE (# 0042671 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINAN(	33.33	SEE ATTACHED	3.1	5.10	SALARY	9,436	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	33.33	SCHEDULES	3.1	5.10	" "	9,436	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	33.33	" "	0.18	0.25	MGMT FEES	36,000	17-3	11
12											12
13								TOTAL	$ 54,872		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	0	$ 0	1
2	5	ELECTRICITY	" "	648,651	14	5,352		33,085	273	2
3	6	REPAIRS	" "	648,651	14	9,448		33,085	482	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	33,085	7,360	4
5	10	NURSING	" "	648,651	14	309,417	309,417	33,085	15,782	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	33,085	4,220	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	33,085	32,992	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		33,085	2,180	8
9	20	DUES/LICENSES/WANT AD	" "	648,651	14	15,220		33,085	776	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	33,085	38,062	10
11	23	SEMINARS	" "	648,651	14	12,554		33,085	640	11
12	24	TRAVEL	" "	648,651	14	1,390		33,085	71	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		33,085	808	13
14	26	INSURANCE	" "	648,651	14	47,123		33,085	2,404	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		33,085	16,733	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		33,085	5,954	16
17	32	INTEREST	" "	648,651	14	11,707		33,085	597	17
18	34	OFFICE RENT	" "	648,651	14	71,276		33,085	3,635	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		33,085	4,538	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 137,507	25

Print Preview

Print Page 8A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE C # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 597	1
2												2
3	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC											3
4	CIB BANK		X	MORTGAGE	$17,387.00	12/98	2,100,000	2,006,315	12/2004	7.75	160,200	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	09/97	30,174	17,831			5,296	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	05/97	55,000	833,000		PRIME+	74,150	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							478	7
8												8
9	TOTAL Facility Related				$17,387.00		$ 2,185,174	$ 2,857,146			$ 240,721	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,185,174	$ 2,857,146			$ 240,721	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	22,970	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	22,519	2
3. Under or (over) accrual (line 2 minus line 1).	$	(451)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	22,740	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	22,289	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	24,985	8
	1996	22,370	9
	1997	23,179	10
	1998	22,743	11
	1999	22,519	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 7,983 2. Number of Years Over Which it is Being Amortized: 5 YRS

3. Current Period Amortization: 1,597 4. Dates Incurred: 5/97

Nature of Costs: ORGANIZATION EXPENSE - LEGAL FEES

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CEN			$	1
2	NURSING HOME: ACRES	8,686	1997	170,000	2
3	TOTALS	8,686		$ 170,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: PRAIRIE VILLAGE HEALTHCA				$	$		$	$	$	4
5	126		1997		1,114,539	28,577	39	28,577		98,850	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ELECTRIC PANEL IN BOILER ROOM			1997	1,192	31	39	31		110	9
10	NURSE CALL SYSTEM			1997	20,424	458	39	458		1,564	10
11	40 TON A/C AND GAS LINE			1997	114,953	2,947	39	2,947		9,702	11
12	NEW ROOF			1997	35,981	923	39	923		2,961	12
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS			1997	18,875	484	39	484		1,553	13
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK			1997	44,010	1,128	39	1,128		3,525	14
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVEI			1997	165,706	4,249	39	4,249		13,279	15
16	FLOOR TILE			1997	35,928	921	39	921		2,801	16
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPI			1997	52,605	1,349	39	1,349		4,103	17
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW			1998	58,466	1,500	39	1,500		4,111	18
19	TILING / FLOORING / DOORS			1998	36,939	948	39	948		2,528	19
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS			1998	69,378	1,778	39	1,778		4,666	20
21	GENERATOR			1998	21,049	540	39	540		1,373	21
22	JFK CONTEMPORARY DESIGNS			1999	3,549	91	39	91		95	22
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES			2000	9,164	104	27.5	104		104	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					54		54			34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 46,082		$ 46,082	$	$ 151,325	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 185,072	$ 26,819	$ 13,739	$ (13,080)	8-15 YRS	$ 43,674	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 5,900 / PRAIRIE VILLAGE L		12,800	12,800				40
41	TOTALS	$ 185,072	$ 39,619	$ 26,539	$ (13,080)		$ 43,674	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 85,701	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 72,621	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (13,080)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 194,999	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 714,174
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipm $ 33,205 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	'98 FORD WINDSTAR	$ 475.00	$ 6,175	17
18					18
19					19
20					20
21	TOTAL		$ 475.00	$ 6,175	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 27,981	$		$ 27,981	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,903			7,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			21,839			21,839	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				17,844		17,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/RENTALS Other (specify):	39-2					6,823		6,823	13
14	TOTAL			$		$ 57,723	$ 24,667		$ 82,390	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	892,143		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,701		6
7	Other Prepaid Expenses	100,727		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,070,174	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	688,220		15
16	Equipment, at Historical Cost	183,619		16
17	Accumulated Depreciation (book methods)	(169,405)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,983		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,790)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM LLC	26,304		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 731,931	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,802,105	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,728	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,015		28
29	Short-Term Notes Payable	833,000		29
30	Accrued Salaries Payable	50,889		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,417		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,740		32
33	Accrued Interest Payable	5,841		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	COMPUTER LEASE	11,002		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,155,632	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,155,632	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 646,473	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,802,105	$	48

***(See instructions.)**

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Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 466,629	1
2	Restatements (describe):		2
3	POST-CLOSING EXPENSES	(12,901)	3
4	ROUNDING	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 453,729	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	234,144	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(41,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 192,744	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 646,473	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENT # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,005,775	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,005,775	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 29	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,005,804	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 568,587	31
32	Health Care	863,385	32
33	General Administration	797,160	33
	B. Capital Expense		
34	Ownership	390,964	34
	C. Ancillary Expense		
35	Special Cost Centers	82,390	35
36	Provider Participation Fee	69,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,771,660	40
41	**Income before Income Taxes (line 30 minus line 40)****	234,144	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 234,144	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,135	2,348	$ 38,777	$ 16.51	1
2	Assistant Director of Nursing	1,251	1,275	20,146	15.80	2
3	Registered Nurses	8,603	9,131	146,922	16.09	3
4	Licensed Practical Nurses	12,827	13,075	133,918	10.24	4
5	Nurse Aides & Orderlies	42,933	44,346	342,670	7.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,972	6,266	65,037	10.38	8
9	Activity Director					9
10	Activity Assistants	4,535	5,056	32,883	6.50	10
11	Social Service Workers	101	103	1,573	15.27	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,070	14,988	7.24	13
14	Head Cook	4,780	5,078	30,818	6.07	14
15	Cook Helpers/Assistants	9,370	9,565	65,946	6.89	15
16	Dishwashers					16
17	Maintenance Workers	2,244	2,286	22,014	9.63	17
18	Housekeepers	14,092	14,575	94,634	6.49	18
19	Laundry	5,068	5,251	46,860	8.92	19
20	Administrator	1,922	2,080	42,672	20.52	20
21	Assistant Administrator	1,928	2,096	31,688	15.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,103	7,581	85,235	11.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	559	589	6,283	10.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,407	132,771	$ 1,223,064 *	$ 9.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,786	1-3	35
36	Medical Director	O	4,090	9-3	36
37	Medical Records Consultant	N	666	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	500	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consulta	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,310	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		1,750	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 25,902		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DIANNA BLACKKETTER	ADMIN		$ 42,672
PAMELA MARSH	ASST ADMIN		31,688
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,360

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEE	$ 77,000
HUNTER MGMT	MANAGEMENT FEES	36,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 113,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 8,800
CAREPLUS MGMT	ADMIN CONSULT	110,000
HDSI	DATA PROC	1,568
AMERICAN DATA	DATA PROC	2,400
KBKB	ACCT	20,600
MEYER MAGENCE	LEGAL	41,376
EDDIE CARPENTER	LEGAL	560
RICHARD PEELO	M/C COST REPORT	3,750
PERSONNEL PLANNERS	UNEMPL CONSULT	1,666
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 190,720

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,408
Unemployment Compensation Insurance	15,979
FICA Taxes	92,794
Employee Health Insurance	13,293
Employee Meals	11,968
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	296
EMPLOYEE BENEFITS-OTHER	6,557
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 174,295

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,499
Health Care Worker Background Chec	732
(Indicate # of checks perform 61)	
ADV & PROMO/MARKETING	12,506
DUES & SUBSCRIPTIONS	3,853
LICENSES & PERMITS	400
TRUST FEES, CONTRIBUTIONS,etc.	101
MGMT CO ALLOCATION	776
LESS TRUST FEES, CONTRIB, etc.	(101)
Less: Public Relations Expense	( )
Non-allowable advertising	(12,506)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,260

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	2,592
MGMT CO ALLOCATION	71
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,663

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Num PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1998	$ 4,042	3	$	$ 674	$ 1,347	$ 1,347	$ 674	$	$	$	$
2													
3													
4													
5													
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9													
10													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,042		$	$ 674	$ 1,347	$ 1,347	$ 674	$	$	$	$

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